FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038760

Facility Name: FLORA PAVILION NURSING HOME CENTER

Address: 701 SHADWELL (Number) FLORA (City) 62839 (Zip Code)

County: CLAY

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-1304216

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) BRADLEY ALTER
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,496	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,185	2,185	8
9	SNF/PED					9
10	ICF	17,837	4,353	120	22,310	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,837	4,353	2,305	24,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 60.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2185

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number FLORA PAVILION NURSING HOME # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	93,367	5,751	8,207	107,325		107,325	0	107,325			1
2	Food Purchase		119,899		119,899		119,899	(4,559)	115,340			2
3	Housekeeping	64,070	17,191	0	81,261		81,261	260	81,521			3
4	Laundry	32,464	10,338	727	43,529		43,529	0	43,529			4
5	Heat and Other Utilities			71,823	71,823		71,823	205	72,028			5
6	Maintenance	39,263	16,348	11,115	66,726		66,726	8,873	75,599			6
7	Other (specify):*			2,756	2,756		2,756	0	2,756			7
8	**TOTAL General Services**	229,164	169,527	94,628	493,319		493,319	4,779	498,098			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	668,420	47,712	8,645	724,777		724,777	4,183	728,960			10
10a	Therapy	12,133	1,146	3,273	16,552		16,552	(4,311)	12,241			10a
11	Activities	49,153	1,926	661	51,740		51,740	0	51,740			11
12	Social Services	20,325		442	20,767		20,767	0	20,767			12
13	Nurse Aide Training			485	485		485	0	485			13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	750,031	50,784	19,506	820,321		820,321	(128)	820,193			16
	C. General Administration											
17	Administrative	50,871		24,650	75,521		75,521	(1,886)	73,635			17
18	Directors Fees			0				0				18
19	Professional Services			26,333	26,333		26,333	11,856	38,189			19
20	Dues, Fees, Subscriptions & Promotions			33,521	33,521		33,521	(16,161)	17,360			20
21	Clerical & General Office Expense	36,595	15,142	99,227	150,964		150,964	(48,595)	102,369			21
22	Employee Benefits & Payroll Taxes			183,763	183,763		183,763	0	183,763			22
23	Inservice Training & Education			1,535	1,535		1,535	0	1,535			23
24	Travel and Seminar			726	726		726	4,408	5,134			24
25	Other Admin. Staff Transportation			6,340	6,340		6,340	2,193	8,533			25
26	Insurance-Prop.Liab.Malpractice			34,188	34,188		34,188	1,345	35,533			26
27	Other (specify):*			0				22,195	22,195			27
28	**TOTAL General Administration**	87,466	15,142	410,283	512,891		512,891	(24,645)	488,246			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,066,661	235,453	524,417	1,826,531		1,826,531	(19,994)	1,806,537			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number FLORA PAVILION NURSING HOME # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,561	31,561		31,561	83,559	115,120			30
31	Amortization of Pre-Op. & Org.							1,186	1,186			31
32	Interest			31,774	31,774		31,774	305,376	337,150			32
33	Real Estate Taxes			44,941	44,941		44,941	0	44,941			33
34	Rent-Facility & Grounds			493,294	493,294		493,294	(362,914)	130,380			34
35	Rent-Equipment & Vehicles			12,761	12,761		12,761	2,817	15,578			35
36	Other (specify):*							0				36
37	TOTAL Ownership			614,331	614,331		614,331	30,024	644,355			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		33,611	65,649	99,260		99,260	0	99,260			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			60,390	60,390		60,390	0	60,390			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		33,611	126,039	159,650		159,650		159,650			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,066,661	269,064	1,264,787	2,600,512	0	2,600,512	10,030	2,610,542			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(18,395)	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,006)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(553)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(1,860)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(17,960)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(104)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	8,804	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,326)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	44,356	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,356		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 10,030		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name FLORA PAVILION NURSING HOME CENTER

IDPH 0020760

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Adj. Summary
The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1** 0
2	**Other Care for Outpatients**	0	0	**Line 2** (4,350)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3** 0
4	**Non-Patient Meals**	0	2	**Line 4** 0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5** 0
6	**Rented Facility Space**	0	34	**Line 6** 8,886
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7** 0
8	**Laundry for Non-Patients**	0	4	**Line 8** 4,504
9	**Non-Straightline Depreciation**	(10,395)	30	**Line 9** 0
10	**Interest and Other Investment Income**	(2)	32	**Line 10** 0
11	**Discounts, Allowances, Rebates & Refunds**	(4,006)	2	**Line 10a** 0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11** 0
13	**Sales Tax**	(553)	2	**Line 12** 0
14	**Non-Care Related Interest**	0	32	**Line 13** 0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14** 0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15** 0
17	**Non-Care Related Fees**	(250)	20	**Line 16** 0
18	**Fines and Penalties**	(1,860)	21	**Line 17** 0
19	**Entertainment**	0	20	**Line 18** 0
20	**Contributions**	0	20	**Line 19** 0
21	**Owner or Key-Man Insurance**	0	22	**Line 20** (18,711)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21** 11,997
23	**Malpractice Insurance for Individuals**	0	26	**Line 22** 0
24	**Bad Debt**	0	27	**Line 23** 0
25	**Fund Raising, Advertising and Promotional**	(17,960)	20	**Line 24** 0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25** 0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26** 0
28	**Yellow Page Advertising**	(104)	20	**Line 27** 0
29	**Non-Paid Workers**	0	0	**Line 28** (20,177)
30	**Donated Goods**	0	0	**Line 29** (15,920)
31	**Amortization Expense**	0	0	**Line 30** (19,589)
32	DEFERRED MAINTENANCE	8,804	6	**Line 31** 0
33				**Line 32** 63
34				**Line 33** 0
35				**Line 34** 0
36				**Line 35** 0
37				**Line 36** 0
38				**Line 37** (18,247)
39				**Line 38** 0
40				**Line 39** 0
41				**Line 40** 0
42				**Line 41** 0
43				**Line 42** 0
44				**Line 43** 0
45				**Line 44** 0
46				**Line 45** (54,120)
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Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,559)	0	0	0	0	0	0	0	0	0	0	(4,559)	2
3	Housekeeping	0	0	260	0	0	0	0	0	0	0	0	260	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	205	0	0	0	0	0	0	0	0	205	5
6	Maintenance	8,804	0	69	0	0	0	0	0	0	0	0	8,873	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	4,245	0	534	0	0	0	0	0	0	0	0	4,779	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,183	0	0	0	0	0	0	0	0	4,183	10
10a	Therapy	0	(26,665)	0	22,354	0	0	0	0	0	0	0	(4,311)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(26,665)	4,183	22,354	0	0	0	0	0	0	0	(128)	16
	C. General Administration													
17	Administrative	0	(24,650)	22,764	0	0	0	0	0	0	0	0	(1,886)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	11,653	203	0	0	0	0	0	0	0	11,856	19
20	Fees, Subscriptions & Promotions	(18,314)	0	2,153	0	0	0	0	0	0	0	0	(16,161)	20
21	Clerical & General Office Expenses	(1,860)	(83,173)	36,367	71	0	0	0	0	0	0	0	(48,595)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,089	319	0	0	0	0	0	0	0	4,408	24
25	Other Admin. Staff Transportation	0	0	1,515	678	0	0	0	0	0	0	0	2,193	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,345	0	0	0	0	0	0	0	0	1,345	26
27	Other (specify):*	0	0	19,438	2,757	0	0	0	0	0	0	0	22,195	27
28	**TOTAL General Administration**	(20,174)	(107,823)	99,324	4,028	0	0	0	0	0	0	0	(24,645)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,929)	(134,488)	104,041	26,382	0	0	0	0	0	0	0	(19,994)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(18,395)	100,086	1,868	0	0	0	0	0	0	0	0	83,559	30
31	Amortization of Pre-Op. & Org.	0	1,186	0	0	0	0	0	0	0	0	0	1,186	31
32	Interest	(2)	305,068	310	0	0	0	0	0	0	0	0	305,376	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(366,059)	3,145	0	0	0	0	0	0	0	0	(362,914)	34
35	Rent-Equipment & Vehicles	0	0	2,264	553	0	0	0	0	0	0	0	2,817	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(18,397)	40,281	7,587	553	0	0	0	0	0	0	0	30,024	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(34,326)	(94,207)	111,628	26,935	0	0	0	0	0	0	0	10,030	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe FLORA PAVILION NURSING HOME CENTEI # 0028760 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEAL	SKOKIE	MANAGEMENT
				MANAGEMENT		BOOKKEEPING
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1 V	17	MANAGEMENT FEES	$ 24,650	CERTIFIED HEALTH MANAGEMEN	0	0	(24,650)	1	-24650
2 V	21	BOOKKEEPING FEES	$2,300	CERTIFIED HEALTH MANAGEMEN			(82,300)	2	-83300
3 V								3	
4 V								4	
5 V	10a	THERAPY	26,665	CHM THERAPY			(26,665)	5	-26665
6 V								6	
7 V	34	RENT	366,059	FLORA PAVILION NURSING HOME LLI			(366,059)	7	-366059
8 V								8	
9 V	21	OFFICE EXPENSI		" " "		127	127	9	127
10 V	20	DEPRECIATION		" " "		100,086	100,086	10	100086
11 V	21	AMORTIZATION		" " "		1,186	1,186	11	1186
12 V	22	INTEREST		" " "		305,068	305,068	12	305068
13 V								13	
14 Total			$ 500,674			$ 406,467	$ * (94,207)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15 V	3	HOUSEKEEPING	$			$ 260	$ 260	15	260
16 V	5	ELECTRICITY & GAS				205	205	16	205
17 V	6	MAINTENANCE				69	69	17	69
18 V	10	NURSING & MEDICAL RECORDS				4,183	4,183	18	4183
19 V	17	ADMIN SALARIES				22,764	22,764	19	22764
20 V	19	PROFESSIONAL FEES				11,653	11,653	20	11653
21 V	20	FEES, SUBSCRIPTION				2,153	2,153	21	2153
22 V	21	OFFICE EXPENSE				36,367	36,367	22	36367
23 V	27	EMPLOYEE BENEFITS				19,438	19,438	23	19438
24 V	24	TRAVEL & SEMINAR				4,089	4,089	24	4089
25 V	25	TRANSPORTATION				1,515	1,515	25	1515
26 V	26	INSURANCE				1,345	1,345	26	1345
27 V	30	DEPRECIATION				1,868	1,868	27	1868
28 V	32	INTEREST				310	310	28	310
29 V	34	OFFICE RENT				3,145	3,145	29	3145
30 V	35	EQUIPMENT RENT				2,264	2,264	30	2264
31 V								31	
32 V								32	
33 V								33	
34 V								34	
35 V								35	
36 V								36	
37 V								37	
38 V								38	
39 Total			$			$ 111,628	$ * 111,628	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	10a	THERAPY	$			$ 22,354	$ 22,354	15	22354
16	V	19	PROFESSIONAL FEE				203	203	16	203
17	V	21	OFFICE EXPENSE				71	71	17	71
18	V	27	EMPLOYEE BENEFITS				2,757	2,757	18	2757
19	V	24	TRAVEL & SEMINARS				319	319	19	319
20	V	25	TRANSPORTATION				678	678	20	678
21	V	35	EQUIPMENT RENT				553	553	21	553
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 26,935	$ * 26,935	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number FLORA PAVILION NURSING HOME # 0038760 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 14,530	17-7	1
2	HOWARD GELLER		ADMINISTRATIVE					MGMT FEE	8,775	19-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,305		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: CERTIFIED HEALTH MANAGEMEN
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674 - 4700
Fax Number: (847) 674 - 4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	282,193	8	$ 3,000	$	24,495	$ 260	1
2	5	ELECTRICITY & GAS	" "	282,193	8	2,363		24,495	205	2
3	6	MAINTENANCE	" "	282,193	8	794		24,495	69	3
4	10	NURSING & MEDICAL REC	" "	282,193	8	48,193	48,193	24,495	4,183	4
5	17	ADMIN SALARIES	" "	282,193	8	262,258	262,258	24,495	22,764	5
6	19	PROFESSIONAL FEES	" "	282,193	8	103,352		24,495	11,653	6
7	20	FEES, SUBSCRIPTION	" "	282,193	8	24,805		24,495	2,153	7
8	21	OFFICE EXPENSE	" "	282,193	8	418,964	287,637	24,495	36,367	8
9	27	EMPLOYEE BENEFITS	" "	282,193	8	223,938		24,495	19,438	9
10	24	TRAVEL & SEMINAR	" "	282,193	8	47,103		24,495	4,089	10
11	25	TRANSPORTATION	" "	282,193	8	17,449		24,495	1,515	11
12	26	INSURANCE	" "	282,193	8	15,497		24,495	1,345	12
13	30	DEPRECIATION	" "	282,193	8	21,518		24,495	1,868	13
14	32	INTEREST	" "	282,193	8	3,570		24,495	310	14
15	34	OFFICE RENT	" "	282,193	8	36,234		24,495	3,145	15
16	35	EQUIPMENT RENT	" "	282,193	8	26,088		24,495	2,264	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,255,126	$ 598,088		$ 111,628	25

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STATE OF ILLINOIS

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: CHM THERAPY
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674 - 4700
Fax Number: (847) 674 - 4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10a	THERAPY	USAGE	100	5	$ 237,623	$ 237,623	9	$ 22,354	1
2	19	PROFESSIONAL FEE	USAGE	100	5	2,171		9	203	2
3	21	OFFICE EXPENSE	USAGE	100	5	762		9	71	3
4	27	EMPLOYEE BENEFITS	USAGE	100	5	29,544		9	2,757	4
5	24	TRAVEL & SEMINARS	USAGE	100	5	3,419		9	319	5
6	25	TRANSPORTATION	USAGE	100	5	7,260		9	678	6
7	35	EQUIPMENT RENT	USAGE	100	5	5,926		9	553	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 286,705	$ 237,623		$ 26,935	25

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number FLORA PAVILION NURSING HOME # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	SUCCESS BANK		X	MORTGAGE	$8,399.00	4/00	$ 405,904	$ 362,414	9/01	10.5	$ 33,789	1
2	GERSHON BASSMAN	X		MORTGAGE	$9,635.00	4/00	1,014,760	1,001,832	3/20	9.75	77,991	2
3	CIB BANK		X	MORTGAGE	$22,639.00	4/00	2,354,244	2,333,666	3/20	9.75	193,288	3
4												4
5												5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL				354,227			21,112	6
7	SHAREHOLDER/OFFICEI	X		WORKING CAPITAL				479,969			10,662	7
8	RELATED PARTY	X									310	8
9	TOTAL Facility Related				$40,673.00		$ 3,774,908	$ 4,532,108			$ 337,152	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,774,908	$ 4,532,108			$ 337,152	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	53,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	48,634	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,666)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	49,607	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	44,941	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	44,237	8
	1996	46,251	9
	1997	49,158	10
	1998	52,251	11
	1999	48,634	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 165,000	1
2					2
3	TOTALS			$ 165,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		2000		$ 2,970,000	$ 76,507	27.5	$ 76,507	$	$ 76,507	4
5											5
6											6
7											7
8						210		210			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	FANS			1993	1,891	48	39	48		362	9
10	ROOF			1993	15,000	385	39	385		2,872	10
11	DRIVEWAY			1993	16,855	432	39	432		3,114	11
12	STRIP PARKING LOT			1993	280	7	39	7		48	12
13	AWNING			1993	948	24	39	24		172	13
14	ROOF			1994	1,909	49	39	49		304	14
15	FRONT ENTRY REPAIR			1996	4,236	109	39	109		522	15
16	DUCT MODIFICATION			1996	11,970	307	39	307		1,343	16
17	CONCRETE WORK			1996	5,510	368	15	368		1,655	17
18	CONSULT REROOFING			1997	540	14	39	14		51	18
19	DOOR ALARM SYSTEM			1997	700	18	39	18		58	19
20	REPLACE ROOF			1997	14,760	378	39	378		1,150	20
21	ROOF TOP AC			1998	10,372	266	39	266		632	21
22	ROLLING DOOR			1998	2,962	76	39	76		168	22
23	CARPET			1998	3,160	81	39	81		179	23
24	ROOF REPAIR			1999	16,688	429	39	429		840	24
25	PAINTING/FLOORING			1999	19,553	501	39	501		945	25
26	SEWER LINE/PUMP/SOIL TESTING			1999	3,537	91	39	91		133	26
27	HOT WATER HEATER			2000	4,579	654	20	114	(540)	114	27
28	ROOF REPAIR			2000	21,518	156	27.5	156		156	28
29	WASH & PAINT BUILDING			2000	4,820	95	27.5	95		95	29
30	BATHROOM REMODEL			2000	10,925	17	27.5	17		17	30
31	AC RETURN			2000	1,000	14	27.5	14		14	31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 81,236		$ 80,696	$ (540)	$ 91,451	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number FLORA PAVILION NURSING HOME CENTE # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 158,869	$ 24,687	$ 15,888	$ (8,799)	10 YRS	$ 52,704	37
38	Current Year Purchases	14,267	2,355	713	(1,642)	10 YRS	713	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	178,232	25,237	17,823	(7,414)			40
41	TOTALS	$ 351,368	$ 52,279	$ 34,424	$ (17,855)		$ 53,417	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 133,515	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 115,120	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (18,395)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 144,868	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____ This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 3,597 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		1997 DODGE VAN	$ 600.00	$ 9,164	17
18					18
19					19
20					20
21	TOTAL		$ 600.00	$ 9,164	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ___

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 32,008	$		$ 32,008	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				9,720			9,720	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				21,176			21,176	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					17,178		17,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): LAB	39 - 2 & 3					2,745	16,433		19,178	13
14	TOTAL				$		$ 65,649	$ 33,611		$ 99,260	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 47,500)	316,222		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,697		6
7	Other Prepaid Expenses	3,291		7
8	Accounts Receivable (owners or related parties)	15,313		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 395,523	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	173,713		15
16	Equipment, at Historical Cost	173,136		16
17	Accumulated Depreciation (book methods)	(118,707)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 228,142	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 623,665	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 406,960	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,000		28
29	Short-Term Notes Payable	354,227		29
30	Accrued Salaries Payable	42,096		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,257		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,607		32
33	Accrued Interest Payable	10,277		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	RE ESCROW SHORTAGE	3,578		36
37	DEFERRED INCOME	52,762		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 923,764	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	479,969		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	669,370		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,149,339	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,073,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,449,438)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 623,665	$	48

***(See instructions.)**

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (838,130)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (838,130)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(611,308)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (611,308)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,449,438)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number FLORA PAVILION NURSING HOME CEN # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,203,961	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,203,961	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	66,176	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 66,176	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 2	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**	4,006	28
28a	**SCHEDULE ATTACHED**	(284,941)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (280,935)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 1,989,204	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 493,319	31
32	Health Care	820,321	32
33	General Administration	512,891	33
	B. Capital Expense		
34	Ownership	614,331	34
	C. Ancillary Expense		
35	Special Cost Centers	99,260	35
36	Provider Participation Fee	60,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,600,512	40
41	**Income before Income Taxes (line 30 minus line 40)****	(611,308)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (611,308)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number FLORA PAVILION NURSING HOME CENTER # 0038760 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,117	2,257	$ 38,828	$ 17.20	1
2	Assistant Director of Nursing	1,960	2,080	34,050	16.37	2
3	Registered Nurses	7,570	7,894	109,245	13.84	3
4	Licensed Practical Nurses	8,946	9,785	110,527	11.30	4
5	Nurse Aides & Orderlies	45,502	46,379	327,646	7.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,904	1,904	12,133	6.37	8
9	Activity Director	1,956	2,088	22,299	10.68	9
10	Activity Assistants	3,274	3,604	26,854	7.45	10
11	Social Service Workers	1,976	2,048	20,325	9.92	11
12	Dietician					12
13	Food Service Supervisor	1,864	1,944	15,183	7.81	13
14	Head Cook	2,190	2,270	13,694	6.03	14
15	Cook Helpers/Assistants	8,731	8,959	64,490	7.20	15
16	Dishwashers					16
17	Maintenance Workers	3,741	3,949	39,263	9.94	17
18	Housekeepers	9,063	11,060	64,070	5.79	18
19	Laundry	5,297	5,578	32,464	5.82	19
20	Administrator	1,960	2,080	42,359	20.36	20
21	Assistant Administrator	660	660	8,512	12.90	21
22	Other Administrative					22
23	Office Manager	2,012	2,112	20,388	9.65	23
24	Clerical	1,939	1,971	16,207	8.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,013	2,053	16,320	7.95	31
32	Other Health Care(specify)					32
33	Other(specify CARE PLAN	3,149	3,173	31,804	10.02	33
34	TOTAL (lines 1 - 33)	117,824	123,848	$ 1,066,661 *	$ 8.61	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,207	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	3,930	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	650	10-3	39
40	Physical Therapy Consultant	L	655	10a-3	40
41	Occupational Therapy Consulta	Y	0	10a-3	41
42	Respiratory Therapy Consultant		28	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	661	11-3	44
45	Social Service Consultant	E	442	12-3	45
46	Other(specify)	S			46
47			0		47
48					48
49	TOTAL (lines 35 - 48)		$ 20,573		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53